

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN3602</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/17/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARDIN CO NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>935 WAYNE ROAD SAVANNAH, TN 38372</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>A review of the NAT program was conducted in conjunction with the annual survey on 3/15/10 to 3/17/10. No deficiencies were cited related to NAT.</p> <p>We recommend recertification of the NAT.</p>	N 000			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1